

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-033500
STATE FILE NUMBER

DO NOT WRITE ON THIS STUB

AMENDED

Registration District No. 373 Primary Registration District No. 4545 Registrar's No. 41

FILED AUG 27 1962

VS 300
Rev. 4/59

1 11.90
2 11.30
3 2
4 0
5 1
6
7 0
8 2
9/20.1
10
11
1290-0
133-0

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY WEBSTER | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MO b. COUNTY WEBSTER | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN MARSHFIELD | | Length of stay in lb 8 YRS | c. CITY OR TOWN MARSHFIELD |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION | | Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/> | d. STREET ADDRESS (If outside, give location) Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> |

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|--|-------------------------------|---|---|----------------------------------|--|--|
| 3. NAME OF DECEASED (Type or print) First HERMAN Middle H. Last HYDE | | | 4. DATE OF DEATH Month AUG Day 10 Year 1962 | | | |
| 5. SEX MALE | 6. COLOR OR RACE WHITE | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 2-7-1900 | 9. AGE (last birthday) 62 | | |

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|---|-----------------------------------|--|---|
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) ABSTRACT BUSINESS | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) MISSOURI | 12. CITIZEN OF WHAT COUNTRY U.S.A. |
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|-------------------------------------|---|--|
| 13a. FATHER'S NAME B.F. HYDE | 13b. MOTHER'S MAIDEN NAME MATTIE HIGHTOWER AETHR. B. | 14. NAME OF SPOUSE OR WIFE LETHA B. HYDE MARSHFIELD |
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|---|-------------------------|---|---------|
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | 16. SOCIAL SECURITY NO. | 17. INFORMANT LETHA B. HYDE MARSHFIELD | Address |
|---|-------------------------|---|---------|

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| 18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: | | INTERVAL BETWEEN ONSET AND DEATH |
| IMMEDIATE CAUSE (a) Coronary thrombosis (203 previous) | | immediate |
| Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. | DUE TO (b) Atherosclerosis | unknown |
| | DUE TO (c) | |

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| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown |
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| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) |
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| 20c. TIME OF INJURY Hour a.m. p.m. | Month, Day, Year |
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|--|--|------------------------------|--------|-------|
| 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION | COUNTY | STATE |
|--|--|------------------------------|--------|-------|

21. I attended the deceased from 1954 to death and last saw her alive on 7-13-62
Death occurred at 350 A.M. on the date stated above, and to the best of my knowledge, from the causes stated.

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| 22a. SIGNATURE <i>[Signature]</i> | (Degree or title) | 22b. ADDRESS <u>Springfield, Mo</u> | 22c. DATE SIGNED <u>8-13-62</u> |
|--------------------------------------|-------------------|--|------------------------------------|

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|--|-------------------------------|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE 8-12-1962 | 23c. NAME OF CEMETERY OR CREMATORY MARSHFIELD | 23d. LOCATION (City, town, or county) (State) MARSHFIELD MO |
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| 24. FUNERAL DIRECTOR BARBER-EDWARDS. MARSHFIELD. | ADDRESS | 25. DATE RECD. BY LOCAL REG. <u>8-15-62</u> | 26. REGISTRAR'S SIGNATURE <i>[Signature]</i> |
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USE BLACK INK OR TYPEWRITER RIBBON

MAY 3 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed George Stapp

Licensed Embalmer No. 3161

P. O. Address McGraw Hill

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.